

FIRST REGULAR SESSION

# HOUSE BILL NO. 646

## 91ST GENERAL ASSEMBLY

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INTRODUCED BY REPRESENTATIVE LUETKENHAUS.

Read 1<sup>st</sup> time February 5, 2001, and 1000 copies ordered printed.

TED WEDEL, Chief Clerk

1627L.011

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### AN ACT

To repeal sections 376.421, 376.424, 376.426, 376.816, 376.960, 376.966, 376.986, 379.930, 379.938, 379.940 and 379.952, RSMo 2000, relating to health insurance, and to enact in lieu thereof fourteen new sections relating to the same subject.

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*Be it enacted by the General Assembly of the state of Missouri, as follows:*

Section A. Sections 376.421, 376.424, 376.426, 376.816, 376.960, 376.966, 376.986, 379.930, 379.938, 379.940 and 379.952, RSMo 2000, are repealed and fourteen new sections enacted in lieu thereof, to be known as sections 376.421, 376.424, 376.426, 376.450, 376.451, 376.452, 376.816, 376.960, 376.966, 376.986, 379.930, 379.938, 379.940 and 379.952, to read as follows:

376.421. 1. Except as provided in subsection 2 of this section, no policy of group health insurance shall be delivered in this state unless it conforms to one of the following descriptions:

(1) A policy issued to an employer, or to the trustees of a fund established by an employer, which employer or trustees shall be deemed the policyholder, to insure employees of the employer for the benefit of persons other than the employer, subject to the following requirements:

(a) The employees eligible for insurance under the policy shall be all of the employees of the employer, or all of any class or classes thereof. The policy may provide that the term "employees" shall include the employees of one or more subsidiary corporations, and the employees, individual proprietors, and partners of one or more affiliated corporations, proprietorships or partnerships, if the business of the employer and of such affiliated corporations, proprietorships or partnerships is under common control. The policy may provide

**EXPLANATION — Matter enclosed in bold faced brackets [thus] in this bill is not enacted and is intended to be omitted in the law.**

13 that the term "employees" shall include the individual proprietor or partners if the employer is  
14 an individual proprietorship or partnership. The policy may provide that the term "employees"  
15 shall include retired employees, former employees and directors of a corporate employer. A  
16 policy issued to insure the employees of a public body may provide that the term "employees"  
17 shall include elected or appointed officials;

18 (b) The premium for the policy shall be paid either from the employer's funds or from  
19 funds contributed by the insured employees, or from both. Except as provided in paragraph (c)  
20 of this subdivision, a policy on which no part of the premium is to be derived from funds  
21 contributed by the insured employees must insure all eligible employees, except those who reject  
22 such coverage in writing; and

23 (c) An insurer may exclude or limit the coverage on any person [as to whom evidence  
24 of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten  
25 employees and in a policy insuring ten or more employees if:

26 a. Application is not made within thirty-one days after the date of eligibility for  
27 insurance; or

28 b. The person voluntarily terminated the insurance while continuing to be eligible for  
29 insurance under the policy; or

30 c. After the expiration of an open enrollment period during which the person could have  
31 enrolled for the insurance or could have elected another level of benefits under the policy] **only**  
32 **to the extent authorized by sections 376.450 to 376.452;**

33 (2) A policy issued to a creditor or its parent holding company or to a trustee or trustees  
34 or agent designated by two or more creditors, which creditor, holding company, affiliate, trustee,  
35 trustees or agent shall be deemed the policyholder, to insure debtors of the creditor or creditors  
36 with respect to their indebtedness subject to the following requirements:

37 (a) The debtors eligible for insurance under the policy shall be all of the debtors of the  
38 creditor or creditors, or all of any class or classes thereof. The policy may provide that the term  
39 "debtors" shall include:

40 a. Borrowers of money or purchasers or lessees of goods, services, or property for which  
41 payment is arranged through a credit transaction;

42 b. The debtors of one or more subsidiary corporations; and

43 c. The debtors of one or more affiliated corporations, proprietorships or partnerships if  
44 the business of the policyholder and of such affiliated corporations, proprietorships or  
45 partnerships is under common control;

46 (b) The premium for the policy shall be paid either from the creditor's funds or from  
47 charges collected from the insured debtors, or from both. Except as provided in paragraph (c)  
48 of this subdivision, a policy on which no part of the premium is to be derived from funds

49 contributed by insured debtors specifically for their insurance must insure all eligible debtors;

50 (c) An insurer may exclude any debtors as to whom evidence of individual insurability  
51 is not satisfactory to the insurer in a policy insuring fewer than ten debtors and in a policy  
52 insuring ten or more debtors if:

53 a. Application is not made within thirty-one days after the date of eligibility for  
54 insurance; or

55 b. The person voluntarily terminated the insurance while continuing to be eligible for  
56 insurance under the policy; or

57 c. After the expiration of an open enrollment period during which the person could have  
58 enrolled for the insurance or could have elected another level of benefits under the policy;

59 (d) The total amount of insurance payable with respect to an indebtedness shall not  
60 exceed the greater of the scheduled or actual amount of unpaid indebtedness to the creditor. The  
61 insurer may exclude any payments which are delinquent on the date the debtor becomes disabled  
62 as defined in the policy;

63 (e) The insurance may be payable to the creditor or to any successor to the right, title,  
64 and interest of the creditor. Such payment or payments shall reduce or extinguish the unpaid  
65 indebtedness of the debtor to the extent of each such payment and any excess of insurance shall  
66 be payable to the insured or the estate of the insured;

67 (f) Notwithstanding the preceding provisions of this subdivision, insurance on  
68 agricultural credit transaction commitments may be written up to the amount of the loan  
69 commitment, and insurance on educational credit transaction commitments may be written up  
70 to the amount of the loan commitment less the amount of any repayments made on the loan;

71 (3) A policy issued to a labor union or similar employee organization, which shall be  
72 deemed to be the policyholder, to insure members of such union or organization for the benefit  
73 of persons other than the union or organization or any of its officials, representatives, or agents,  
74 subject to the following requirements:

75 (a) The members eligible for insurance under the policy shall be all of the members of  
76 the union or organization, or all of any class or classes thereof;

77 (b) The premium for the policy shall be paid either from funds of the union or  
78 organization or from funds contributed by the insured members specifically for their insurance,  
79 or from both. Except as provided in paragraph (c) of this subdivision, a policy on which no part  
80 of the premium is to be derived from funds contributed by the insured members specifically for  
81 their insurance must insure all eligible members, except those who reject such coverage in  
82 writing;

83 (c) An insurer may exclude or limit the coverage on any person [as to whom evidence  
84 of individual insurability is not satisfactory to the insurer in a policy insuring fewer than ten

85 members and in a policy insuring ten or more members if:

86       a. Application is not made within thirty-one days after the date of eligibility for  
87 insurance; or

88       b. The person voluntarily terminated the insurance while continuing to be eligible for  
89 insurance under the policy; or

90       c. After the expiration of an open enrollment period during which the person could have  
91 enrolled for the insurance or could have elected another level of benefits under the policy] **only**  
92 **to the extent authorized by sections 376.450 to 376.452;**

93       (4) A policy issued to a trust, or to the trustee of a fund, established or adopted by two  
94 or more employers, or by one or more labor unions or similar employee organizations, or by one  
95 or more employers and one or more labor unions or similar employee organizations, which trust  
96 or trustee shall be deemed the policyholder, to insure employees of the employers or members  
97 of the unions or organizations for the benefit of persons other than the employers or the unions  
98 or organizations, subject to the following requirements:

99       (a) The persons eligible for insurance shall be all of the employees of the employers or  
100 all of the members of the unions or organizations, or all of any class or classes thereof. The  
101 policy may provide that the term "employees" shall include the employees of one or more  
102 subsidiary corporations, and the employees, individual proprietors, and partners of one or more  
103 affiliated corporations, proprietorships or partnerships if the business of the employer and of such  
104 affiliated corporations, proprietorships or partnerships is under common control. The policy may  
105 provide that the term "employees" shall include the individual proprietor or partners if the  
106 employer is an individual proprietorship or partnership. The policy may provide that the term  
107 "employees" shall include retired employees, former employees and directors of a corporate  
108 employer. The policy may provide that the term "employees" shall include the trustees or their  
109 employees, or both, if their duties are principally connected with such trusteeship;

110       (b) The premium for the policy shall be paid from funds contributed by the employer or  
111 employers of the insured persons or by the union or unions or similar employee organizations,  
112 or by both, or from funds contributed by the insured persons or from both the insured persons  
113 and the employer or union or similar employee organization. Except as provided in paragraph  
114 (c) of this subdivision, a policy on which no part of the premium is to be derived from funds  
115 contributed by the insured persons specifically for their insurance, must insure all eligible  
116 persons except those who reject such coverage in writing;

117       (c) An insurer may exclude or limit the coverage on any person [as to whom evidence  
118 of individual insurability is not satisfactory to the insurer] **only to the extent authorized by**  
119 **sections 376.450 to 376.452;**

120       (5) A policy issued to an association or to a trust or to the trustees of a fund established,

121 created and maintained for the benefit of members of one or more associations. The association  
122 or associations shall have at the outset a minimum of one hundred persons; shall have been  
123 organized and maintained in good faith for purposes other than that of obtaining insurance; shall  
124 have been in active existence for at least two years; shall have a constitution and bylaws which  
125 provide that the association or associations shall hold regular meetings not less than annually to  
126 further the purposes of the members; shall, except for credit unions, collect dues or solicit  
127 contributions from members; and shall provide the members with voting privileges and  
128 representation on the governing board and committees. The policy shall be subject to the  
129 following requirements:

130 (a) The policy may insure members of such association or associations, employees  
131 thereof, or employees of members, or one or more of the preceding, or all of any class or classes  
132 thereof for the benefit of persons other than the employee's employer;

133 (b) The premium for the policy shall be paid from funds contributed by the association  
134 or associations or by employer members, or by both, or from funds contributed by the covered  
135 persons or from both the covered persons and the association, associations, or employer  
136 members;

137 (c) Except as provided in paragraph (d) of this subdivision, a policy on which no part of  
138 the premium is to be derived from funds contributed by the covered persons specifically for their  
139 insurance must insure all eligible persons, except those who reject such coverage in writing;

140 (d) An insurer may exclude or limit the coverage on any person [as to whom evidence  
141 of individual insurability is not satisfactory to the insurer] **only to the extent authorized by**  
142 **sections 376.450 to 376.452;**

143 (6) A policy issued to a credit union or to a trustee or trustees or agent designated by two  
144 or more credit unions, which credit union, trustee, trustees or agent shall be deemed the  
145 policyholder, to insure members of such credit union or credit unions for the benefit of persons  
146 other than the credit union or credit unions, trustee or trustees, or agent or any of their officials,  
147 subject to the following requirements:

148 (a) The members eligible for insurance shall be all of the members of the credit union  
149 or credit unions, or all of any class or classes thereof;

150 (b) The premium for the policy shall be paid by the policyholder from the credit union's  
151 funds and, except as provided in paragraph (c) of this subdivision, must insure all eligible  
152 members;

153 (c) An insurer may exclude or limit the coverage on any member [as to whom evidence  
154 of individual insurability is not satisfactory to the insurer] **only to the extent authorized by**  
155 **sections 376.450 to 376.452;**

156 (7) A policy issued to cover persons in a group where that group is specifically described

157 by a law of this state as one which may be covered for group life insurance. The provisions of  
158 such law relating to eligibility and evidence of insurability shall apply.

159 2. Group health insurance offered to a resident of this state under a group health  
160 insurance policy issued to a group other than one described in subsection 1 of this section shall  
161 be subject to the following requirements:

162 (1) No such group health insurance policy shall be delivered in this state unless the  
163 director finds that:

164 (a) The issuance of such group policy is not contrary to the best interest of the public;

165 (b) The issuance of the group policy would result in economies of acquisition or  
166 administration; and

167 (c) The benefits are reasonable in relation to the premiums charged;

168 (2) No such group health insurance coverage may be offered in this state by an insurer  
169 under a policy issued in another state unless this state or another state having requirements  
170 substantially similar to those contained in subdivision (1) of this subsection has made a  
171 determination that such requirements have been met;

172 (3) The premium for the policy shall be paid either from the policyholder's funds, or  
173 from funds contributed by the covered persons, or from both;

174 (4) An insurer may exclude or limit the coverage on any person [as to whom evidence  
175 of individual insurability is not satisfactory to the insurer] **only to the extent authorized by**  
176 **sections 376.450 to 376.452.**

376.424. Except for a policy issued under subdivision (2) of subsection 1 of section  
2 376.421, a group health insurance policy may be extended to insure the employees and members  
3 with respect to their family members or dependents, or any class or classes thereof, subject to the  
4 following:

5 (1) The premium for the insurance shall be paid either from funds contributed by the  
6 employer, union, association or other person to whom the policy has been issued or from funds  
7 contributed by the covered persons, or from both. Except as provided in subdivision (2) of this  
8 section, a policy on which no part of the premium for the family members' or dependents'  
9 coverage is to be derived from funds contributed by the covered persons must insure all eligible  
10 employees or members with respect to their family members or dependents, or any class or  
11 classes thereof;

12 (2) An insurer may exclude or limit the coverage on any family member or dependent  
13 [as to whom evidence of individual insurability is not satisfactory to the insurer], subject to  
14 sections 376.406 and 376.776 [in a policy insuring fewer than ten employees or members and  
15 in a policy insuring ten or more employees or members if:

16 a. Application is not made within thirty-one days after the date of eligibility for

17 insurance; or

18       b. The employee or member voluntarily terminated the insurance of the family member  
19 or dependent while such family member or dependent continues to be eligible for insurance  
20 under the policy; or

21       c. After the expiration of an open enrollment period during which the family member  
22 or dependent could have been enrolled for the insurance or could have been enrolled for another  
23 level of benefits under the policy], **only to the extent authorized by sections 376.450 to**  
24 **376.452.**

      376.426. No policy of group health insurance shall be delivered in this state unless it  
2 contains in substance the following provisions, or provisions which in the opinion of the director  
3 of insurance are more favorable to the persons insured or at least as favorable to the persons  
4 insured and more favorable to the policyholder; except that: Provisions in subdivisions (5), (7),  
5 (12), (15), and (16) of this section shall not apply to policies insuring debtors; standard  
6 provisions required for individual health insurance policies shall not apply to group health  
7 insurance policies; and if any provision of this section is in whole or in part inapplicable to or  
8 inconsistent with the coverage provided by a particular form of policy, the insurer, with the  
9 approval of the director, shall omit from such policy any inapplicable provision or part of a  
10 provision, and shall modify any inconsistent provision or part of the provision in such manner  
11 as to make the provision as contained in the policy consistent with the coverage provided by the  
12 policy:

13       (1) A provision that the policyholder is entitled to a grace period of thirty-one days for  
14 the payment of any premium due except the first, during which grace period the policy shall  
15 continue in force, unless the policyholder shall have given the insurer written notice of  
16 discontinuance in advance of the date of discontinuance and in accordance with the terms of the  
17 policy. The policy may provide that the policyholder shall be liable to the insurer for the payment  
18 of a pro rata premium for the time the policy was in force during such grace period;

19       (2) A provision that the validity of the policy shall not be contested, except for  
20 nonpayment of premiums, after it has been in force for two years from its date of issue, and that  
21 no statement made by any person covered under the policy relating to insurability shall be used  
22 in contesting the validity of the insurance with respect to which such statement was made after  
23 such insurance has been in force prior to the contest for a period of two years during such  
24 person's lifetime nor unless it is contained in a written instrument signed by the person making  
25 such statement; except that, no such provision shall preclude the assertion at any time of defenses  
26 based upon the person's ineligibility for coverage under the policy or upon other provisions in  
27 the policy;

28       (3) A provision that a copy of the application, if any, of the policyholder shall be

29 attached to the policy when issued, that all statements made by the policyholder or by the persons  
30 insured shall be deemed representations and not warranties and that no statement made by any  
31 person insured shall be used in any contest unless a copy of the instrument containing the  
32 statement is or has been furnished to such person or, in the event of the death or incapacity of  
33 the insured person, to the individual's beneficiary or personal representative;

34 (4) A provision setting forth the conditions, if any, under which the insurer reserves the  
35 right to require a person eligible for insurance to furnish evidence of individual insurability  
36 satisfactory to the insurer as a condition to part or all of the individual's coverage;

37 (5) A provision specifying the additional exclusions or limitations, if any, applicable  
38 under the policy with respect to a disease or physical condition of a person, not otherwise  
39 excluded from the person's coverage by name or specific description effective on the date of the  
40 person's loss, which existed prior to the effective date of the person's coverage under the policy.  
41 Any such exclusion or limitation [may only apply to a disease or physical condition for which  
42 medical advice or treatment was received by the person during the twelve months prior to the  
43 effective date of the person's coverage. In no event shall such exclusion or limitation apply to  
44 loss incurred or disability commencing after the earlier of:

45 (a) The end of a continuous period of twelve months commencing on or after the  
46 effective date of the person's coverage during all of which the person has received no medical  
47 advice or treatment in connection with such disease or physical condition; or

48 (b) The end of the two-year period commencing on the effective date of the person's  
49 coverage] **shall comply with the requirements of subsection 5 of section 376.450;**

50 (6) If the premiums or benefits vary by age, there shall be a provision specifying an  
51 equitable adjustment of premiums or of benefits, or both, to be made in the event the age of the  
52 covered person has been misstated, such provision to contain a clear statement of the method of  
53 adjustment to be used;

54 (7) A provision that the insurer shall issue to the policyholder, for delivery to each  
55 person insured, a certificate setting forth a statement as to the insurance protection to which that  
56 person is entitled, to whom the insurance benefits are payable, and a statement as to any family  
57 member's or dependent's coverage;

58 (8) A provision that written notice of claim must be given to the insurer within twenty  
59 days after the occurrence or commencement of any loss covered by the policy. Failure to give  
60 notice within such time shall not invalidate nor reduce any claim if it shall be shown not to have  
61 been reasonably possible to give such notice and that notice was given as soon as was reasonably  
62 possible;

63 (9) A provision that the insurer shall furnish to the person making claim, or to the  
64 policyholder for delivery to such person, such forms as are usually furnished by it for filing proof



65 of loss. If such forms are not furnished before the expiration of fifteen days after the insurer  
66 receives notice of any claim under the policy, the person making such claim shall be deemed to  
67 have complied with the requirements of the policy as to proof of loss upon submitting, within  
68 the time fixed in the policy for filing proof of loss, written proof covering the occurrence,  
69 character, and extent of the loss for which claim is made;

70 (10) A provision that in the case of claim for loss of time for disability, written proof of  
71 such loss must be furnished to the insurer within ninety days after the commencement of the  
72 period for which the insurer is liable, and that subsequent written proofs of the continuance of  
73 such disability must be furnished to the insurer at such intervals as the insurer may reasonably  
74 require, and that in the case of claim for any other loss, written proof of such loss must be  
75 furnished to the insurer within ninety days after the date of such loss. Failure to furnish such  
76 proof within such time shall not invalidate nor reduce any claim if it was not reasonably possible  
77 to furnish such proof within such time, provided such proof is furnished as soon as reasonably  
78 possible and in no event, except in the absence of legal capacity of the claimant, later than one  
79 year from the time proof is otherwise required;

80 (11) A provision that all benefits payable under the policy other than benefits for loss of  
81 time shall be payable not more than thirty days after receipt of proof and that, subject to due  
82 proof of loss, all accrued benefits payable under the policy for loss of time shall be paid not less  
83 frequently than monthly during the continuance of the period for which the insurer is liable, and  
84 that any balance remaining unpaid at the termination of such period shall be paid as soon as  
85 possible after receipt of such proof;

86 (12) A provision that benefits for accidental loss of life of a person insured shall be  
87 payable to the beneficiary designated by the person insured or, if the policy contains conditions  
88 pertaining to family status, the beneficiary may be the family member specified by the policy  
89 terms. In either case, payment of these benefits is subject to the provisions of the policy in the  
90 event no such designated or specified beneficiary is living at the death of the person insured. All  
91 other benefits of the policy shall be payable to the person insured. The policy may also provide  
92 that if any benefit is payable to the estate of a person, or to a person who is a minor or otherwise  
93 not competent to give a valid release, the insurer may pay such benefit, up to an amount not  
94 exceeding two thousand dollars, to any relative by blood or connection by marriage of such  
95 person who is deemed by the insurer to be equitably entitled thereto;

96 (13) A provision that the insurer shall have the right and opportunity, at the insurer's own  
97 expense, to examine the person of the individual for whom claim is made when and so often as  
98 it may reasonably require during the pendency of the claim under the policy and also the right  
99 and opportunity, at the insurer's own expense, to make an autopsy in case of death where it is not  
100 prohibited by law;

101 (14) A provision that no action at law or in equity shall be brought to recover on the  
102 policy prior to the expiration of sixty days after proof of loss has been filed in accordance with  
103 the requirements of the policy and that no such action shall be brought at all unless brought  
104 within three years from the expiration of the time within which proof of loss is required by the  
105 policy;

106 (15) A provision specifying the conditions under which the policy may be terminated.  
107 Such provision shall state that except for nonpayment of the required premium or the failure to  
108 meet continued underwriting standards, the insurer may not terminate the policy prior to the first  
109 anniversary date of the effective date of the policy as specified therein, and a notice of any  
110 intention to terminate the policy by the insurer must be given to the policyholder at least  
111 thirty-one days prior to the effective date of the termination. Any termination by the insurer shall  
112 be without prejudice to any expenses originating prior to the effective date of termination. An  
113 expense will be considered incurred on the date the medical care or supply is received;

114 (16) A provision stating that if a policy provides that coverage of a dependent child  
115 terminates upon attainment of the limiting age for dependent children specified in the policy,  
116 such policy, so long as it remains in force, shall be deemed to provide that attainment of such  
117 limiting age does not operate to terminate the hospital and medical coverage of such child while  
118 the child is and continues to be both incapable of self-sustaining employment by reason of  
119 mental or physical handicap and chiefly dependent upon the policyholder for support and  
120 maintenance. Proof of such incapacity and dependency must be furnished to the insurer by the  
121 policyholder at least thirty-one days before the child's attainment of the limiting age. The insurer  
122 may require at reasonable intervals during the two years following the child's attainment of the  
123 limiting age subsequent proof of the child's incapacity and dependency. After such two-year  
124 period, the insurer may require subsequent proof not more than once each year. This subdivision  
125 shall apply only to policies delivered or issued for delivery in this state on or after one hundred  
126 twenty days after September 28, 1985;

127 (17) In the case of a policy insuring debtors, a provision that the insurer shall furnish to  
128 the policyholder for delivery to each debtor insured under the policy a certificate of insurance  
129 describing the coverage and specifying that the benefits payable shall first be applied to reduce  
130 or extinguish the indebtedness.

**376.450. 1. As used in sections 376.450 to 376.452, the following terms mean:**

2 (1) "Affiliation period", a period which, under the terms of the coverage offered  
3 by a health maintenance organization, must expire before the coverage becomes effective.  
4 The organization is not required to provide health care services or benefits during such  
5 period and no premium shall be charged to the participant or beneficiary for any coverage  
6 during the period;

- 7           (2) "Bona fide association", an association which:  
8           (a) Has been actively in existence for at least five years;  
9           (b) Has been formed and maintained in good faith for purposes other than  
10 obtaining insurance;  
11           (c) Does not condition membership in the association on any health status-related  
12 factor relating to an individual (including an employee of an employer or a dependent of  
13 an employee);  
14           (d) Makes health insurance coverage offered through the association available to  
15 all members regardless of any health status-related factor relating to such members (or  
16 individuals eligible for coverage through a member); and  
17           (e) Does not make health insurance coverage offered through the association  
18 available other than in connection with a member of the association.  
19           (3) "COBRA continuation provision":  
20           (a) Section 4980B of the Internal Revenue Code (26 U.S.C. 4980B), other than  
21 Subsection (f)(1) of that section as it relates to pediatric vaccines;  
22           (b) Title I, Subtitle B, Part 6, excluding Section 609, of the Employee Retirement  
23 Income Security Act of 1974; or  
24           (c) Title XXII of the Public Health Service Act, 42 U.S.C. 300dd, et seq.  
25           (4) "Creditable coverage", coverage of the individual under any of the following:  
26           (a) A group health plan;  
27           (b) Health insurance coverage;  
28           (c) Part A or Part B of Title XVIII of the Social Security Act ("Medicare");  
29           (d) Title XIX of the Social Security Act ("Medicaid"), other than coverage  
30 consisting solely of benefits under section 1928 of such act (the program for distribution  
31 of pediatric vaccines);  
32           (e) Chapter 55 of Title 10, United States Code (medical and dental care for  
33 members and certain former members of the uniformed services);  
34           (f) A medical care program of the Indian Health Service or of a tribal organization;  
35           (g) A state health benefits risk pool;  
36           (h) A health plan offered under Title 5, Chapter 89, of the United States Code (the  
37 Federal Employees Health Benefits Program);  
38           (i) A public health plan (established or maintained by the state or a political  
39 subdivision thereof providing health insurance coverage);  
40           (j) A health benefit plan under section 5(e) of the Peace Corps Act (22 U.S.C.  
41 2504(3)).  
42

43 **Creditable coverage does not include coverage consisting solely of excepted benefits.**

44 **(5) "Enrollment date", with respect to an individual covered under a group health**  
45 **plan, the date of enrollment of the individual in the plan or, if earlier, the first day of the**  
46 **waiting period for enrollment.**

47 **(6) "Excepted benefits":**

48 **(a) Coverage only for accident (including accidental death and dismemberment)**  
49 **insurance;**

50 **(b) Coverage only for disability income insurance;**

51 **(c) Coverage issued as a supplement to liability insurance;**

52 **(d) Liability insurance, including general liability insurance and automobile**  
53 **liability insurance;**

54 **(e) Workers' compensation or similar insurance;**

55 **(f) Automobile medical payment insurance;**

56 **(g) Credit-only insurance;**

57 **(h) Coverage for onsite medical clinics;**

58 **(i) Other similar insurance coverage, as approved by the director, under which**  
59 **benefits for medical care are secondary or incidental to other insurance benefits;**

60 **(j) If provided under a separate policy, certificate or contract of insurance, any of**  
61 **the following:**

62 **a. Limited scope dental or vision benefits;**

63 **b. Benefits for long-term care, nursing home care, home health care, community-**  
64 **based care, or any combination thereof;**

65 **c. Other similar, limited benefits as specified by the director.**

66 **(k) If provided under a separate policy, certificate or contract of insurance, any of**  
67 **the following:**

68 **a. Coverage only for a specified disease or illness;**

69 **b. Hospital indemnity or other fixed indemnity insurance.**

70 **(l) If offered as a separate policy, certificate or contract of insurance, any of the**  
71 **following:**

72 **a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the**  
73 **Social Security Act);**

74 **b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title**  
75 **10, United States Code (CHAMPUS supplemental programs);**

76 **c. Similar supplemental coverage provided to coverage under a group health plan.**

77 **(7) "Group health insurance coverage", health insurance coverage offered in**  
78 **connection with a group health plan or health insurance coverage offered to an eligible**

79 group as described in section 376.421;

80 (8) "Group health plan", an employee welfare benefit plan as defined in section 3  
81 of the Employee Retirement Income Security Act of 1974 to the extent that the plan  
82 provides medical care and items and services paid for as medical care to employees or their  
83 dependents, directly or through insurance, reimbursement, or otherwise;

84 (9) "Health insurance coverage", benefits consisting of medical care, including  
85 items and services paid for as medical care, that are provided directly, through insurance,  
86 reimbursement, or otherwise, under a policy, certificate, membership contract, or health  
87 services agreement offered by a health insurance issuer;

88 (10) "Health insurance issuer", an insurance company, health services corporation,  
89 fraternal benefit society, health maintenance organization, multiple employer welfare  
90 arrangement specifically authorized to operate in the state of Missouri, or any other entity  
91 providing a plan of health insurance or health benefits subject to state insurance  
92 regulation;

93 (11) "Individual health insurance coverage", health insurance coverage offered to  
94 individuals in the individual market, not including short-term limited duration insurance;

95 (12) "Individual market", the market for health insurance coverage offered to  
96 individuals other than in connection with a group health plan;

97 (13) "Large employer", in connection with a group health plan, with respect to a  
98 calendar year and a plan year, an employer who employed an average of at least fifty-one  
99 employees on business days during the preceding calendar year and who employs at least  
100 two employees on the first day of the plan year;

101 (14) "Large group market", the health insurance market under which individuals  
102 obtain health insurance coverage directly or through any arrangement on behalf of  
103 themselves and their dependents through a group health plan maintained by a large  
104 employer;

105 (15) "Late enrollee", a participant who enrolls in a group health plan other than  
106 during the first period in which the individual is eligible to enroll under the plan, or a  
107 special enrollment period pursuant to subsection 3 of section 376.450;

108 (16) "Medical care":

109 (a) The diagnosis, cure, mitigation, treatment, or prevention of disease or amounts  
110 paid for the purpose of affecting any structure or function of the body;

111 (b) Transportation primarily for and essential to medical care referred to in  
112 paragraph (a) of this subdivision; or

113 (c) Insurance covering medical care referred to in paragraphs (a) and (b) of this  
114 subdivision.

(17) "Network plan", health insurance coverage offered by a health insurance issuer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers under contract with the issuer;

(18) "Participant", a person enrolled for coverage under a group health plan;

(19) "Plan sponsor", the entity described in section 3 of the Employee Retirement Income Security Act of 1974;

(20) "Preexisting condition exclusion", with respect to coverage, a limitation or exclusion of benefits relating to a condition based on the fact that the condition was present before the date of enrollment for such coverage, whether or not any medical advice, diagnosis, care, or treatment was recommended or received before such date. Genetic information shall not be treated as a preexisting condition in the absence of a diagnosis of the condition related to such information;

(21) "Small group market", the health insurance market under which individuals obtain health insurance coverage directly or through an arrangement, on behalf of themselves and their dependents, through a group health plan maintained by a small employer as defined in subdivision (28) of section 379.930, RSMo;

(22) "Waiting period", with respect to a group health plan and an individual who is a potential participant in a group health plan, the period that must pass with respect to the individual before the individual is eligible to be covered for benefits under the terms of the group health plan.

2. (1) No period of creditable coverage that occurs before a sixty-three day break in coverage during which the individual was not covered under any creditable coverage need be considered for purposes of paragraph (c) of subdivision (1) of subsection 5 of section 376.450.

(2) Any period of time that an individual is in a waiting period for coverage under group health insurance coverage, or is in an affiliation period, shall not be taken into account in determining whether a sixty-three day break under subdivision (1) of this subsection has occurred.

(3) Except as provided in subdivision (4) of this subsection, for the purposes of applying paragraph (c) of subdivision (1) of subsection 5 of section 376.450, a health insurance issuer offering group health insurance coverage shall count a period of creditable coverage without regard to the specific benefits included in the coverage.

(4) (a) A health insurance issuer offering group health insurance coverage may elect to apply the provisions of paragraph (c) of subdivision (1) of subsection 5 of section 376.450, based on coverage within any category of benefits within each of several classes

or categories of benefits specified in regulations implementing Public Law 104-191, rather than as provided pursuant to subdivision (3) of this subsection. Such election shall be made on a uniform basis for all participants. Under such election a health insurance issuer shall count a period of creditable coverage with respect to any class or category of benefits if any level of benefits is covered within the class or category.

(b) In the case of an election with respect to health insurance coverage offered by a health insurance issuer in the small or large group market pursuant to this subdivision, the health insurance issuer shall prominently state in any disclosure statements concerning the coverage, and prominently state to each employer at the time of the offer or sale of the coverage, that the issuer has made such election, and include in such statements a description of the effect of this election.

(5) Periods of creditable coverage with respect to an individual may be established through presentation of certifications and other means as specified in Public Law 104-191 and regulations pertinent thereto.

3. (1) A health insurance issuer offering group health insurance in connection with a group health plan shall permit an employee or a dependent of an employee who is eligible but not enrolled for coverage under the terms of the plan to enroll for coverage if:

(a) The employee or dependent was covered under a group health plan or had health insurance coverage at the time that coverage was previously offered to the employee or dependent;

(b) The employee stated in writing at the time that coverage under a group health plan or health insurance coverage was the reason for declining enrollment, but only if the plan sponsor or health insurance issuer required the statement at the time and provided the employee with notice of the requirement and the consequences of the requirement at the time;

(c) The employee's or dependent's coverage described in paragraph (a) of this subdivision was:

a. Under a COBRA continuation provision and was exhausted; or

b. Not under a COBRA continuation provision and was terminated as a result of loss of eligibility for the coverage or because employer contributions toward the cost of coverage were terminated; and

(d) Under the terms of the group health plan, the employee requests the enrollment not later than thirty days after the date of exhaustion of coverage described in subparagraph a. of paragraph (c) of this subdivision or termination of coverage or employer contributions described in subparagraph b. of paragraph (c) of this subdivision.

(2) (a) A group health plan shall provide for a dependent special enrollment period

described in paragraph (b) of this subdivision during which an employee who is eligible but not enrolled and a dependent may be enrolled under the group health plan and, in the case of the birth or adoption of a child, the spouse of the employee may be enrolled as a dependent if the spouse is otherwise eligible for coverage.

(b) A dependent special enrollment period pursuant to this subdivision is a period of not less than thirty days that begins on the date of the marriage, birth, or adoption or placement for adoption.

(3) The coverage becomes effective:

(a) In the case of marriage, not later than the first day of the first month beginning after the date on which the completed request for enrollment is received;

(b) In the case of a dependent's birth, as of the date of birth; or

(c) In the case of a dependent's adoption or placement for adoption, the date of the adoption or placement for adoption.

4. A health insurance issuer offering group health insurance coverage shall provide a certification of creditable coverage as required by Public Law 104-191 and regulations pertinent thereto.

5. (1) A health insurance issuer offering group health insurance coverage may with respect to a participant impose a preexisting condition exclusion if:

(a) Such exclusion relates to a condition (whether physical or mental), regardless of the cause of the condition, for which medical advice, diagnosis, care, or treatment was recommended or received within the six-month period ending on the enrollment date;

(b) Such exclusion extends for a period of not more than twelve months (or eighteen months in the case of a late enrollee) after the enrollment date; and

(c) The period of any such preexisting condition exclusion is reduced by the aggregate of the periods of creditable coverage, if any, applicable to the participant as of the enrollment date.

(2) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of an individual who, as of the last day of the thirty-day period beginning with the date of birth, is covered under creditable coverage.

(3) Subject to subdivision (5) of this subsection, a health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion in the case of a child who is adopted or placed for adoption before attaining eighteen years of age and who, as of the last day of the thirty-day period beginning on the date of the adoption or placement for adoption, is covered under creditable coverage. The previous sentence shall not apply to coverage before the date of such adoption or placement for adoption.



(4) A health insurance issuer offering group health insurance coverage may not impose any preexisting condition exclusion relating to pregnancy as a preexisting condition.

(5) Subdivisions (2) and (3) of this subsection shall no longer apply to an individual after the end of the first sixty-three-day period during all of which the individual was not covered under any creditable coverage.

(6) In the case of group health insurance coverage offered by a health maintenance organization, the plan may provide for an affiliation period with respect to coverage through the organization only if:

(a) No preexisting condition exclusion is imposed with respect to coverage through the organization;

(b) The period is applied uniformly without regard to any health status-related factors;

(c) Such period does not exceed two months (or three months in the case of a late enrollee);

(d) Such period begins on the enrollment date; and

(e) Such period runs concurrently with any waiting period.

**376.451. 1. (1)** A health insurance issuer offering group health insurance coverage may not establish rules for eligibility, including continued eligibility, of any individual to enroll under the terms of the group health plan based on any of the following health status-related factors of the individual or a dependent of the individual:

(a) Health status;

(b) Medical condition, including both physical and mental illness;

(c) Claims experience;

(d) Receipt of health care;

(e) Medical history;

(f) Genetic information;

(g) Evidence of insurability, including conditions arising out of acts of domestic violence; or

(h) Disability.

(2) This subsection does not require a health insurance issuer offering group health insurance coverage to provide particular benefits other than those provided under the terms of the group health insurance coverage, or prevent the issuer from establishing limitations or restrictions on the amount, level, extent, or nature of the benefits or coverage for similarly situated individuals enrolled in the group health insurance coverage.

(3) For purposes of subdivision (1) of this subsection, rules for eligibility to enroll

20 include rules defining any applicable waiting or affiliation period for such enrollment, and  
21 rules relating to late and special enrollments.

22       2. (1) A health insurance issuer offering health insurance coverage in connection  
23 with a group health plan may not require any individual, as a condition of enrollment or  
24 continued enrollment under the plan, to pay a premium or contribution that is greater than  
25 the premium or contribution for a similarly situated individual enrolled in the group  
26 health plan on the basis of any health status-related factor in relation to the individual or  
27 to an individual enrolled under the plan as a dependent of the individual.

28       (2) Nothing in subdivision (1) of this subsection shall be construed to:

29       (a) Restrict the amount that any employer may be charged for coverage under a  
30 group health plan; or

31       (b) Prevent a health insurance issuer offering group health insurance coverage,  
32 from establishing premium discounts or rebates or modifying otherwise applicable  
33 copayments or deductibles in return for adherence to programs of health promotion and  
34 disease prevention.

376.452. 1. Except as provided in this section, if a health insurance issuer offers  
2 health insurance coverage in the large group market in connection with a group health  
3 plan, the health insurance issuer shall renew or continue the coverage in force at the option  
4 of the plan sponsor.

5       2. A health insurance issuer may nonrenew or discontinue health insurance  
6 coverage offered in connection with a group health plan in the large group market if:

7       (1) The plan sponsor has failed to pay premiums or contributions in accordance  
8 with the terms of the health insurance coverage or if the health insurance issuer has not  
9 received timely premium payments;

10       (2) The plan sponsor has performed an act or practice that constitutes fraud or has  
11 made an intentional misrepresentation of material fact in connection with the coverage;

12       (3) The plan sponsor has failed to comply with the health insurance issuer's  
13 minimum participation requirements;

14       (4) The plan sponsor has failed to comply with the health insurance issuer's  
15 employer contribution requirements;

16       (5) The health insurance issuer is ceasing to offer coverage in that group market  
17 in accordance with this section;

18       (6) In the case of a health insurance issuer that offers health insurance coverage in  
19 the group market through a network plan, there is no longer any enrollee under the group  
20 health plan who lives, resides, or works in the service area of the health insurance issuer;

21       (7) In the case of health insurance coverage that is made available in the small

22 group market or large group market only through one or more bona fide associations, the  
23 membership of an employer in the bona fide association ceases, but only if coverage is  
24 terminated pursuant to this subdivision uniformly without regard to any health status-  
25 related factor of any covered individual.

26 3. A health insurance issuer may not discontinue offering a particular type of group  
27 health insurance coverage offered in the large group market unless:

28 (1) The issuer provides notice to each plan sponsor and participant provided  
29 coverage of this type in that group market of the discontinuation at least ninety days prior  
30 to the date of the discontinuation of the coverage;

31 (2) The issuer offers to each plan sponsor provided coverage of this type in the  
32 market the option to purchase any other health insurance coverage currently being offered  
33 by the health insurance issuer to a group health plan in the market; and

34 (3) The issuer acts uniformly without regard to the claims experience of those plan  
35 sponsors or any health status-related factor of any participant covered or new participant  
36 who may become eligible for such coverage.

37 4. (1) A health insurance issuer may not discontinue offering all health insurance  
38 coverage in the large group market unless:

39 (a) The issuer provides notice of discontinuation to the director and to each plan  
40 sponsor and participant covered at least one hundred eighty days prior to the date of the  
41 discontinuation of coverage; and

42 (b) All health insurance issued or delivered for issuance in Missouri in the large  
43 group market is discontinued and coverage under such health insurance is not renewed.

44 (2) In the case of a discontinuation pursuant to this subsection, the health insurance  
45 issuer may not provide for the issuance of any health insurance coverage in the large group  
46 market for a period of five years beginning on the date of the discontinuation of the last  
47 health insurance coverage not renewed.

48 5. At the time of coverage renewal a health insurance issuer may modify the health  
49 insurance coverage for a product offered to a group health plan in the large group market.

50 6. In the case of health insurance coverage that is made available by a health  
51 insurance issuer only through one or more bona fide associations, references to "plan  
52 sponsor" in this section is deemed, with respect to coverage provided to an employer  
53 member of the association, to include a reference to such employer.

376.816. 1. No individual or group insurance policy providing coverage on an  
2 expense-incurred basis, no individual or group service or indemnity contract issued by a  
3 not-for-profit health services corporation, no health maintenance organization nor any  
4 self-insured group health benefit plan of any type or description shall be offered, issued or

5 renewed in this state on or after July 10, 1991, unless the policy, plan or contract covers adopted  
6 children of the insured, subscriber or enrollee on the same basis as other dependents.

7 2. The coverage required by subsection 1 of this section is effective:

8 (1) From the date of birth if a petition for adoption is filed within thirty days of the birth  
9 of such child; or

10 (2) From the date of placement for the purpose of adoption if a petition for adoption is  
11 filed within thirty days of placement of such child. Such coverage shall continue unless the  
12 placement is disrupted prior to legal adoption and the child is removed from placement.  
13 Coverage shall include the necessary care and treatment of medical conditions existing prior to  
14 the date of placement.

15 3. As used in this section, "placement" means [in the physical custody of the adoptive  
16 parent] **the assumption and retention by the insured, subscriber or enrollee of a legal**  
17 **obligation for total or partial support of such child in anticipation of adoption of such**  
18 **child. The child's placement with such person terminates upon the termination of such**  
19 **legal obligation.**

376.960. As used in sections 376.960 to 376.989, the following terms mean:

2 (1) "Benefit plan", the coverages to be offered by the pool to eligible persons pursuant  
3 to the provisions of section 376.986;

4 (2) "Board", the board of directors of the pool;

5 (3) **"Church plan", a plan as defined in section 3(33) of the Employee Retirement**  
6 **Income Security Act of 1974;**

7 (4) "Director", the director of the Missouri department of insurance;

8 [(4)] (5) "Department", the Missouri department of insurance;

9 (6) **"Federally defined eligible individual", an individual:**

10 (a) **For whom, as of the date on which the individual seeks coverage through the**  
11 **pool, the aggregate of the periods of creditable coverage as defined in subdivision (5) of**  
12 **section 376.450, is eighteen or more months and whose most recent prior creditable**  
13 **coverage was under a group health plan as defined in subdivision (8) of subsection 1 of**  
14 **section 376.450, governmental plan as defined in section 3(32) of the Employee Retirement**  
15 **Income Security Act of 1974, church plan, or health insurance coverage offered in**  
16 **connection with any such plan;**

17 (b) **Who is not eligible for coverage under a group health plan, Part A or Part B of**  
18 **Title XVIII of the Social Security Act, or state plan under Title XIX of such act;**

19 (c) **Who does not have other health insurance coverage;**

20 (d) **For whom the most recent coverage within the coverage period described in**  
21 **paragraph (a) of this subdivision was not terminated because of nonpayment of premiums**

22 **or fraud;**

23 **(e) Who, if offered the option of continuation coverage under COBRA continuation**  
24 **provision as defined in subdivision (3) of subsection 1 of section 376.450, or under a similar**  
25 **state program, both elected and exhausted the continuation coverage.**

26 [(5)] (7) "Health insurance", any hospital and medical expense incurred policy, nonprofit  
27 health care service for benefits other than through an insurer, nonprofit health care service plan  
28 contract, health maintenance organization subscriber contract, preferred provider arrangement  
29 or contract, or any other similar contract or agreement for the provisions of health care benefits.  
30 The term "health insurance" does not include short-term, accident, fixed indemnity, limited  
31 benefit or credit insurance, coverage issued as a supplement to liability insurance, insurance  
32 arising out of a workers' compensation or similar law, automobile medical-payment insurance,  
33 or insurance under which benefits are payable with or without regard to fault and which is  
34 statutorily required to be contained in any liability insurance policy or equivalent self-insurance;

35 [(6)] (8) "Health maintenance organization", any person which undertakes to provide or  
36 arrange for basic and supplemental health care services to enrollees on a prepaid basis, or which  
37 meets the requirements of section 1301 of the United States Public Health Service Act;

38 [(7)] (9) "Hospital", a place devoted primarily to the maintenance and operation of  
39 facilities for the diagnosis, treatment or care for not less than twenty-four hours in any week of  
40 three or more nonrelated individuals suffering from illness, disease, injury, deformity or other  
41 abnormal physical condition; or a place devoted primarily to provide medical or nursing care for  
42 three or more nonrelated individuals for not less than twenty-four hours in any week. The term  
43 "hospital" does not include convalescent, nursing, shelter or boarding homes, as defined in  
44 chapter 198, RSMo;

45 [(8)] (10) "Insurance arrangement", any plan, program, contract or other arrangement  
46 under which one or more employers, unions or other organizations provide to their employees  
47 or members, either directly or indirectly through a trust or third party administration, health care  
48 services or benefits other than through an insurer;

49 [(9)] (11) "Insured", any individual resident of this state who is eligible to receive  
50 benefits from any insurer or insurance arrangement, as defined in this section;

51 [(10)] (12) "Insurer", any insurance company authorized to transact health insurance  
52 business in this state, any nonprofit health care service plan act, or any health maintenance  
53 organization;

54 [(11)] (13) "Medicare", coverage [under] **pursuant to** both Part A and Part B of Title  
55 XVIII of the Social Security Act, 42 U.S.C. 1395 et seq., as amended;

56 [(12)] (14) "Member", all insurers and insurance arrangements participating in the pool;

57 [(13)] (15) "Physician", physicians and surgeons licensed [under] **pursuant to** chapter

58 334, RSMo, or by state board of healing arts in the state of Missouri;

59 [(14)] **(16)** "Plan of operation", the plan of operation of the pool, including articles,  
60 bylaws and operating rules, adopted by the board pursuant to the provisions of sections 376.961,  
61 376.962 and 376.964;

62 [(15)] **(17)** "Pool", the state health insurance pool created in sections 376.961, 376.962  
63 and 376.964.

376.966. 1. No employee shall involuntarily lose his **or her** group coverage by decision  
2 of his **or her** employer on the grounds that such employee may subsequently enroll in the pool.  
3 The department of insurance shall have authority to promulgate rules and regulations to enforce  
4 this subsection.

5 2. **An individual person shall be eligible for benefit plan coverage if the individual**  
6 **is and continues to be a resident of this state and the applicant provides evidence of the**  
7 **following:**

8 **(1) A notice of rejection or refusal to issue substantially similar insurance for health**  
9 **reasons by one insurer; or**

10 **(2) A refusal by an insurer to issue insurance except at a rate exceeding one**  
11 **hundred fifty percent of the standard risk rate calculated pursuant to subsection 4 of**  
12 **section 376.986.**

13 3. Any individual who is a resident of this state **and not otherwise eligible pursuant**  
14 **to subsection 1 of this section** shall be eligible for pool coverage, except the following:

15 (1) Persons who have, on the date of issue of coverage by the pool, coverage under  
16 health insurance or an insurance arrangement except that this exclusion shall not apply to a  
17 person who has such coverage but whose premiums have increased to three hundred percent or  
18 more of rates established by the board as applicable for individual standard risks;

19 (2) Any person who is at the time of pool application receiving health care benefits  
20 [under] **pursuant to** section 208.151, RSMo;

21 (3) [Any person having terminated coverage in the pool unless twelve months have  
22 elapsed since such termination;

23 (4) Any person on whose behalf the pool has paid out one million dollars in benefits;

24 (5)] Inmates of public institutions and persons eligible for public programs;

25 [(6)] **(4)** Any person whose medical condition which precludes other insurance coverage  
26 is directly due to alcohol or drug abuse or self-inflicted injury;

27 [(7)] **(5)** Any person who is eligible for continuation or conversion of insurance coverage  
28 [under] **pursuant to** 29 U.S.C. 1161 to 29 U.S.C. 1168, 42 U.S.C. 300bb-1 to 42 U.S.C.  
29 300bb-8, sections 376.395 to 376.404, or section 376.428, except that this exclusion shall not  
30 apply to a person who has such coverage but whose premiums have increased to [three] **one**

31 hundred **fifty** percent or more of rates established by the board as applicable for individual  
32 standard risks; or

33       ~~[(8)]~~ **(6)** Any person who is eligible for Medicare coverage.

34       ~~[3.]~~ **4.** Any person who ceases to meet the eligibility requirements of this section **or**  
35 **maintain residency in this state** may be terminated at the end of ~~[his]~~ **such person's** policy  
36 period.

37       ~~[4.]~~ **5.** Any person whose health insurance coverage is involuntarily terminated for any  
38 reason other than nonpayment of premium or any person whose premiums have increased to  
39 three hundred percent or more of rates established by the board as applicable for individual  
40 standard risks, may apply for coverage under the plan. If such coverage is applied for within  
41 sixty days after the involuntary termination and the application is approved and if premiums are  
42 paid for the entire coverage period, the effective date of the coverage shall be the date of  
43 termination of the previous coverage.

376.986. 1. The pool shall offer major medical expense coverage to every person  
2 eligible for coverage ~~[under]~~ **pursuant to** section 376.966. The coverage to be issued by the  
3 pool and its schedule of benefits, exclusions and other limitations, shall be established by the  
4 board with the advice and recommendations of the pool members, and such plan of pool  
5 coverage shall be submitted to the director for approval. The pool shall also offer coverage for  
6 drugs and supplies requiring a medical prescription and coverage for patient education services,  
7 to be provided at the direction of a physician, encompassing the provision of information,  
8 therapy, programs, or other services on an inpatient or outpatient basis, designed to restrict,  
9 control, or otherwise cause remission of the covered condition, illness or defect.

10       2. In establishing the pool coverage the board shall take into consideration the levels of  
11 health insurance provided in this state and medical economic factors as may be deemed  
12 appropriate, and shall promulgate benefit levels, deductibles, coinsurance factors, exclusions and  
13 limitations determined to be generally reflective of and commensurate with health insurance  
14 provided through a representative number of insurers in this state.

15       3. Premiums charged for pool coverage may not be unreasonable in relation to the  
16 benefits provided, the risk experience and the reasonable expenses of providing the coverage.  
17 Separate schedules of premium rates based on age, sex and geographical location may apply for  
18 individual risks.

19       4. The pool shall determine the standard risk rate by calculating the average individual  
20 standard rate charged by the five insurers with the largest number of individual contracts in force.  
21 In the event five insurers do not offer comparable coverage, the standard risk rate shall be  
22 established using reasonable actuarial techniques and shall reflect anticipated experience and  
23 expenses for such coverage. Initial rates for pool coverage shall not be less than one hundred

24 fifty percent of rates established as applicable for individual standard risks. Subsequent rates  
25 shall be established to provide fully for the expected costs of claims including recovery of prior  
26 losses, expenses of operation, investment income of claim reserves, and any other cost factors  
27 subject to the limitations described herein. In no event shall pool rates exceed [two hundred  
28 percent of rates applicable to individual standard risks] **the following: for federally defined**  
29 **eligible individuals, one hundred thirty-five percent of rates applicable to individual**  
30 **standard risks; for all other individuals covered under the pool, one hundred fifty percent**  
31 **of rates applicable to individual standard risks.** All rates and rate schedules shall be  
32 submitted to the director for approval.

33 5. Pool coverage established pursuant to this section shall provide an appropriate high  
34 and low deductible to be selected by the pool applicant. The deductibles and coinsurance factors  
35 may be adjusted annually in accordance with the medical component of the consumer price  
36 index.

37 6. Pool coverage shall exclude charges or expenses incurred during the first twelve  
38 months following the effective date of coverage as to any condition which, during the six-month  
39 period immediately preceding the effective date of coverage, had manifested itself in such a  
40 manner as would cause an ordinarily prudent person to seek diagnosis, care or treatment or for  
41 which medical advice, care or treatment was recommended or received as to such condition.  
42 Such preexisting condition exclusions shall be waived to the extent to which similar exclusions,  
43 if any, have been satisfied under any prior health insurance coverage which was [involuntarily]  
44 terminated, if that application for pool coverage is made not later than [sixty] **sixty-three** days  
45 following such [involuntary] termination and, in such case, coverage in the pool shall be  
46 effective from the date on which such prior coverage was terminated.

47 7. Benefits otherwise payable under pool coverage shall be reduced by all amounts paid  
48 or payable through any other health insurance, or insurance arrangement, and by all hospital and  
49 medical expense benefits paid or payable under any workers' compensation coverage, automobile  
50 medical payment or liability insurance whether provided on the basis of fault or nonfault, and  
51 by any hospital or medical benefits paid or payable under or provided pursuant to any state or  
52 federal law or program except Medicaid. The insurer or the pool shall have a cause of action  
53 against an eligible person for the recovery of the amount of benefits paid which are not for  
54 covered expenses. Benefits due from the pool may be reduced or refused as a setoff against any  
55 amount recoverable [under] **pursuant to** this subsection.

56 8. Medical expenses shall include expenses for comparable benefits for those who rely  
57 solely on spiritual means through prayer for healing.

379.930. 1. Sections 379.930 to 379.952 shall be known and may be cited as the "Small  
2 Employer Health Insurance Availability Act".



3           2. For the purposes of sections 379.930 to 379.952, **the following terms shall mean:**

4           (1) "Actuarial certification" [means], a written statement by a member of the American  
5 Academy of Actuaries or other individual acceptable to the director that a small employer carrier  
6 is in compliance with the provisions of section 379.936, based upon the person's examination,  
7 including a review of the appropriate records and of the actuarial assumptions and methods used  
8 by the small employer carrier in establishing premium rates for applicable health benefit plans;

9           (2) "Affiliate" or "affiliated" [means], any entity or person who directly or indirectly  
10 through one or more intermediaries, controls or is controlled by, or is under common control  
11 with, a specified entity or person;

12           (3) "Agent" means "insurance agent" as that term is defined in section 375.012, RSMo;

13           (4) "Base premium rate" [means], for each class of business as to a rating period, the  
14 lowest premium rate charged or that could have been charged under the rating system for that  
15 class of business, by the small employer carrier to small employers with similar case  
16 characteristics for health benefit plans with the same or similar coverage;

17           (5) ["Basic health benefit plan" means a lower cost health benefit plan developed  
18 pursuant to section 379.944;

19           (6) "Board" [means], the board of directors of the program established pursuant to  
20 sections 379.942 and 379.943;

21           [(7)] (6) "Broker" means "broker" as that term is defined in section 375.012, RSMo;

22           [(8)] (7) "Carrier" [means], any entity that provides health insurance or health benefits  
23 in this state. For the purposes of sections 379.930 to 379.952, carrier includes an insurance  
24 company, health services corporation, fraternal benefit society, health maintenance organization,  
25 multiple employer welfare arrangement specifically authorized to operate in the state of  
26 Missouri, or any other entity providing a plan of health insurance or health benefits subject to  
27 state insurance regulation;

28           [(9)] (8) "Case characteristics" [means], demographic or other objective characteristics  
29 of a small employer that are considered by the small employer carrier in the determination of  
30 premium rates for the small employer, provided that claim experience, health status and duration  
31 of coverage since issue shall not be case characteristics for the purposes of sections 379.930 to  
32 379.952;

33           [(10)] (9) "Class of business" [means], all or a separate grouping of small employers  
34 established pursuant to section 379.934;

35           (10) **"Church plan", the meaning given such term in section 3(33) of the Employee**  
36 **Retirement Income Security Act of 1974;**

37           (11) "Committee" [means], the health benefit plan committee created pursuant to section  
38 379.944;

39 (12) "Control" shall be defined in manner consistent with chapter 382, RSMo;

40 (13) **"Creditable coverage", with respect to an individual:**

41 **(a) Coverage of the individual pursuant to any of the following:**

42 **a. A group health plan;**

43 **b. Health insurance coverage;**

44 **c. Part A or Part B of Title XVIII of the Social Security Act;**

45 **d. Title XIX of the Social Security Act, other than coverage consisting solely of**  
46 **benefits pursuant to Section 1928 of such act;**

47 **e. Chapter 55 of Title 10, United States Code;**

48 **f. A medical care program of the Indian Health Service or of a tribal organization;**

49 **g. A state health benefits risk pool;**

50 **h. A health plan offered pursuant to Chapter 89 of Title 5, United States Code;**

51 **i. A public health plan, as defined in federal regulations authorized by Section**  
52 **2701(c)(1)(I) of the Public Health Services Act, as amended by P.L. 104-191; and**

53 **j. A health benefit plan pursuant to Section 5(e) of the Peace Corps Act (22 U.S.C.**  
54 **2504(e));**

55 **(b) Creditable coverage shall not include coverage consisting solely of excepted**  
56 **benefits;**

57 **(c) A period of creditable coverage shall not be counted, with respect to enrollment**  
58 **of an individual if, after such period and before the enrollment date, there was a sixty-**  
59 **three-day period during all of which the individual was not covered under any creditable**  
60 **coverage;**

61 **(14) "Dependent" [means], a spouse or an unmarried child under the age of nineteen**  
62 **years; an unmarried child who is a full-time student under the age of twenty-three years and who**  
63 **is financially dependent upon the parent; or an unmarried child of any age who is medically**  
64 **certified as disabled and dependent upon the parent;**

65 **[(14)] (15) "Director" [means], the director of the department of insurance of this state;**

66 **[(15)] (16) "Eligible employee" [means], an employee who works on a full-time basis**  
67 **and has a normal work week of thirty or more hours. The term includes a sole proprietor, a**  
68 **partner of a partnership, and an independent contractor, if the sole proprietor, partner or**  
69 **independent contractor is included as an employee under a health benefit plan of a small**  
70 **employer, but does not include an employee who works on a part-time, temporary or substitute**  
71 **basis[. For purposes of sections 379.930 to 379.952, a person, his spouse and his minor children**  
72 **shall constitute only one eligible employee when they are employed by the same small**  
73 **employer];**

74 **[(16)] (17) "Established geographic service area" [means], a geographical area, as**

75 approved by the director and based on the carrier's certificate of authority to transact insurance  
76 in this state, within which the carrier is authorized to provide coverage;

77 **(18) "Excepted benefits":**

78 **(a) Coverage only for accident (including accidental death and dismemberment)**  
79 **insurance;**

80 **(b) Coverage only for disability income insurance;**

81 **(c) Coverage issued as a supplement to liability insurance;**

82 **(d) Liability insurance, including general liability insurance and automobile**  
83 **liability insurance;**

84 **(e) Workers' compensation or similar insurance;**

85 **(f) Automobile medical payment insurance;**

86 **(g) Credit-only insurance;**

87 **(h) Coverage for onsite medical clinics;**

88 **(i) Other similar insurance coverage, as approved by the director, under which**  
89 **benefits for medical care are secondary or incidental to other insurance benefits;**

90 **(j) If provided under a separate policy, certificate or contract of insurance, any of**  
91 **the following:**

92 **a. Limited scope dental or vision benefits;**

93 **b. Benefits for long-term care, nursing home care, home health care, community-**  
94 **based care, or any combination thereof;**

95 **c. Other similar, limited benefits as specified by the director.**

96 **(k) If provided under a separate policy, certificate or contract of insurance, any of**  
97 **the following:**

98 **a. Coverage only for a specified disease or illness;**

99 **b. Hospital indemnity or other fixed indemnity insurance.**

100 **(l) If offered as a separate policy, certificate or contract of insurance, any of the**  
101 **following:**

102 **a. Medicare supplemental coverage (as defined under section 1882(g)(1) of the**  
103 **Social Security Act);**

104 **b. Coverage supplemental to the coverage provided pursuant to Chapter 55 of Title**  
105 **10, United States Code (CHAMPUS supplemental programs);**

106 **c. Similar supplemental coverage provided to coverage under a group health plan.**

107 **[(17)] (19) "Government plan", the meaning given such term pursuant to Section**  
108 **3(32) of the Employee Retirement Income Security Act of 1974 or any federal government**  
109 **plan;**

110 **(20) "Group health plan", an employee welfare benefit plan as defined in Section**

**3(1) of the Employee Retirement Income Security Act of 1974 to the extent that the plan provides medical care, as defined in this section, and including any item or service paid for as medical care to an employee or the employee's dependent, as defined under the terms of the plan, directly or through insurance, reimbursement or otherwise. For purposes of sections 379.930 to 379.952:**

**(a) Any plan, fund or program which would not be, but for this subdivision, an employee welfare benefit plan except pursuant to the provisions of this subdivision, and which is established or maintained by a partnership to the extent that such plan, fund or program provides medical care, including any item or service paid for as medical care to a present or former partner in such partnership, or to the partner's dependents, as defined under the terms of the plan, fund or program, directly or through insurance, reimbursement or otherwise, shall be treated, subject to paragraph (b) of this subdivision, as an employee welfare benefit plan which is a group health plan;**

**(b) In the case of a group health plan, the term "employer" also includes a partnership in relation to any partner; and**

**(c) In the case of a group health plan, the term "participant" also includes:**

**a. In connection with a group health plan maintained by a partnership, an individual who is a partner in relation to a partnership; or**

**b. In connection with a group health plan maintained by a self-employed individual under which one or more employees are participants, the self-employed individual, if such individual is or may become eligible to receive a benefit under the plan or such individual's beneficiary may be eligible to receive any such benefit;**

**(21) "Health benefit plan" [means], any hospital or medical policy or certificate, health services corporation contract, or health maintenance organization subscriber contract. Health benefit plan does not include a policy of individual accident and sickness insurance or hospital supplemental policies having a fixed daily benefit, or accident-only, specified disease-only, credit, dental, vision, Medicare supplement, long-term care, or disability income insurance, or coverage issued as a supplement to liability insurance, worker's compensation or similar insurance, or automobile medical payment insurance;**

**(22) "Health status-related factor", any of the following:**

**(a) Health status;**

**(b) Medical condition, including both physical and mental illnesses;**

**(c) Claims experience;**

**(d) Receipt of health care;**

**(e) Medical history;**

**(f) Genetic information;**

(g) **Evidence of insurability, including a condition arising out of an act of domestic violence;**

(h) **Disability;**

[(18)] (23) "Index rate" [means], for each class of business as to a rating period for small employers with similar case characteristics, the arithmetic mean of the applicable base premium rate and the corresponding highest premium rate;

[(19)] (24) "Late enrollee" [means], an eligible employee or dependent who requests enrollment in a health benefit plan of a small employer following the initial enrollment period for which such individual is entitled to enroll under the terms of the health benefit plan, provided that such initial enrollment period is a period of at least thirty days. However, an eligible employee or dependent shall not be considered a late enrollee if:

(a) The individual meets each of the following:

a. The individual was covered under [qualifying previous] **creditable** coverage at the time of the initial enrollment;

b. The individual lost coverage under [qualifying previous] **creditable** coverage as a result of **cessation of employer contribution**, termination of employment or eligibility, **reduction in the number of hours of employment**, the involuntary termination of the [qualifying previous] **creditable** coverage, death of a spouse [or divorce;], **dissolution or legal separation; and**

c. The individual requests enrollment within thirty days after termination of the [qualifying previous] **creditable** coverage;

(b) The individual is employed by an employer that offers multiple health benefit plans and the individual elects a different plan during an open enrollment period; or

(c) A court has ordered coverage be provided for a spouse or minor or dependent child under a covered employee's health benefit plan and request for enrollment is made within thirty days after issuance of the court order;

[(20)] (25) "**Medical care**", an amount paid for:

(a) **The diagnosis, care, mitigation, treatment or prevention of disease, or for the purpose of affecting any structure or function of the body;**

(b) **Transportation primarily for and essential to medical care referred to in paragraph (a) of this subdivision; or**

(c) **Insurance covering medical care referred to in paragraphs (a) and (b) of this subdivision;**

(26) "**Network plan**", a health benefit plan that requires an enrollee to use or creates incentives, including financial incentives, for an enrollee to use, health care providers managed, owned, under contract with or employed by the health carrier;

183           (27) "New business premium rate" [means], for each class of business as to a rating  
184 period, the lowest premium rate charged or offered, or which could have been charged or offered,  
185 by the small employer carrier to small employers with similar case characteristics for newly  
186 issued health benefit plans with the same or similar coverage;

187           [(21)] (28) "Plan of operation" [means], the plan of operation of the program established  
188 pursuant to sections 379.942 and 379.943;

189           [(22)] (29) **"Plan sponsor", the meaning given such term pursuant to Section**  
190 **3(16)(B) of the Employee Retirement Income Security Act of 1974;**

191           (30) "Premium" [means], all moneys paid by a small employer and eligible employees  
192 as a condition of receiving coverage from a small employer carrier, including any fees or other  
193 contributions associated with the health benefit plan;

194           [(23)] (31) "Producer" includes an insurance agent or broker;

195           [(24)] (32) **"Professional association", an association which meets all of the**  
196 **following:**

197           (a) **Serves a single profession, if such profession requires a significant amount of**  
198 **education, training or experience, or a license or certificate from a state authority to**  
199 **practice such profession;**

200           (b) **Has been actively in existence for five years;**

201           (c) **Has a constitution or bylaws, or any other analogous governing document;**

202           (d) **Has been formed and maintained in good faith for a purpose other than**  
203 **obtaining insurance;**

204           (e) **Is not owned or controlled by a carrier or affiliated with a carrier;**

205           (f) **Does not condition membership in the association on health status or claims**  
206 **experience;**

207           (g) **Has at least one thousand members if it is a national association; five hundred**  
208 **members if it is a state association; or two hundred members if it is a local association;**

209           (h) **Any member or dependent of a member is eligible for coverage regardless of**  
210 **health status or claims experience;**

211           (i) **Does not offer a health benefit plan to an individual through the association**  
212 **other than in connection with a member of the association;**

213           (j) **Is governed by a board of directors and sponsors annual meetings of its**  
214 **members; and**

215           (k) **Producers may only market an association membership, accept an application**  
216 **for membership, or sign up a member in the professional association if such individual is**  
217 **actively engaged in, or directly related to, the profession represented by the professional**  
218 **association;**

(33) "Professional association plan", a health benefit plan offered through a professional association that covers members of a professional association and their dependents in this state regardless of the situs of delivery of the policy or contract and meets the following:

(a) Conforms with the provisions of section 379.936 concerning the premium rates as they apply to an individual carrier and individual health benefit plan;

(b) Provides renewability of coverage for the members and dependents of members of a professional association which meets the requirements set forth in subsection 2 of section 379.938 as applied to an individual health benefit plan;

(c) Provides availability of coverage for the members and dependents of members of the professional association in conformance with the provisions of subdivisions (1), (2) and (3) of subsection 2 of section 379.940 as applied to an individual health benefit plan and individual carrier;

(d) Is offered by a carrier that offers health benefit plan coverage to any professional association seeking health benefit plan coverage from such carrier; and

(e) Conforms with the preexisting condition provisions of subsection 2 of section 379.940 as applied to an individual health benefit plan;

(34) "Program" [means], the Missouri small employer health reinsurance program created pursuant to sections 379.942 and 379.943;

[(25) "Qualifying previous coverage" and "qualifying existing coverage" mean benefits or coverage provided under:

(a) Medicare or Medicaid;

(b) An employer-based health insurance or health benefit arrangement that provides benefits similar to or exceeding benefits provided under the basic health benefit plan; or

(c) An individual health insurance policy (including coverage issued by a health maintenance organization, health services corporation or a fraternal benefit society) that provides benefits similar to or exceeding the benefits provided under the basic health benefit plan, provided that such policy has been in effect for a period of at least one year;

(26)] (35) "Rating period" [means], the calendar period for which premium rates established by a small employer carrier are assumed to be in effect;

[(27)] (36) "Restricted network provision" [means], any provision of a health benefit plan that conditions the payment of benefits, in whole or in part, on the use of health care providers that have entered into a contractual arrangement with the carrier pursuant to [section 354.400, RSMo, et seq.] sections 354.400 to 354.550, RSMo, to provide health care services to covered individuals;

[(28)] (37) "Small employer" [means], in connection with a group health plan with

255 **respect to a calendar year and a plan year**, any person, firm, corporation, partnership [or],  
256 association **or political subdivision** that is actively engaged in business that[, on at least fifty  
257 percent of its working days during the preceding calendar quarter, employed not less than three  
258 nor] **employed an average of at least two but no** more than [twenty-five] **fifty** eligible  
259 employees[, the majority of whom were employed within this state. In determining the number  
260 of eligible employees, companies that are affiliated companies, or that are eligible to file a  
261 combined tax return for purposes of state taxation, shall be considered one employer;] **on**  
262 **business days during the preceding calendar year and that employs at least two employees**  
263 **on the first day of the plan year. All persons treated as a single employer pursuant to**  
264 **subsection (b), (c), (m) or (o) of Section 414 of the Internal Revenue Code of 1986 shall be**  
265 **treated as one employer. Subsequent to the issuance of a health plan to a small employer**  
266 **and for the purpose of determining continued eligibility, the size of a small employer shall**  
267 **be determined annually. Except as otherwise specifically provided, the provisions of**  
268 **sections 379.930 to 379.952 that apply to a small employer shall continue to apply at least**  
269 **until the plan anniversary following the date the small employer no longer meets the**  
270 **requirements of this definition. In the case of an employer which was not in existence**  
271 **throughout the preceding calendar year, the determination of whether the employer is a**  
272 **small or large employer shall be based on the average number of employees that it is**  
273 **reasonably expected that the employer will employ on business days in the current**  
274 **calendar year. Any reference in this act to an employer shall include a reference to any**  
275 **predecessor of such employer;**

276 [(29)] **(38)** "Small employer carrier" [means], a carrier that offers health benefit plans  
277 covering eligible employees of one or more small employers in this state[;

278 (30) "Standard health benefit plan" means a health benefit plan developed pursuant to  
279 section 379.944].

379.938. 1. A health benefit plan subject to sections 379.930 to 379.952 shall be  
2 renewable with respect to all eligible employees and dependents, at the option of the small  
3 employer, except in any of the following cases:

4 (1) [Nonpayment of the required premiums] **The plan sponsor fails to pay a premium**  
5 **or contribution in accordance with the terms of a health benefit plan or the health carrier**  
6 **has not received a timely premium payment;**

7 (2) [Fraud or misrepresentation of the small employer or, with respect to coverage of  
8 individual insureds, the insureds or their representatives] **The plan sponsor performs an act**  
9 **or practice that constitutes fraud, or makes an intentional misrepresentation of material**  
10 **fact under the terms of the coverage;**

11 (3) Noncompliance with the carrier's minimum participation requirements;



- 12 (4) Noncompliance with the carrier's employer contribution requirements;
- 13 (5) [Repeated misuse of a provider network provision; or] **In the case of a small**
- 14 **employer carrier that offers coverage through a network plan, there is no longer any**
- 15 **enrollee under the health benefit plan who lives, resides or works in the service area of the**
- 16 **health insurance issuer;**
- 17 (6) **The small employer carrier discontinues offering a particular type of group**
- 18 **health benefit plan in the state's small employer market. A type of health benefit plan may**
- 19 **be discontinued by a small employer carrier in such market only if such carrier:**
- 20 (a) **Issues a notice to each plan sponsor and participant provided coverage of such**
- 21 **type of the discontinuation at least ninety days prior to the date of discontinuation of the**
- 22 **coverage;**
- 23 (b) **Offers to each plan sponsor provided coverage of such type the option to**
- 24 **purchase any of the health benefit plans currently being offered by the small employer**
- 25 **carrier in the state's small employer market; and**
- 26 (c) **Acts uniformly without regard to the claims experience of those plan sponsors**
- 27 **or any health status-related factor relating to any participant covered or new participant**
- 28 **who may become eligible for such coverage;**
- 29 (7) **A small employer carrier may not discontinue offering all health insurance**
- 30 **coverage in the small employer market unless:**
- 31 (a) **The carrier provides notice of discontinuation to the director and to each plan**
- 32 **sponsor and participant covered at least one hundred eighty days prior to the date of the**
- 33 **discontinuation of coverage; and**
- 34 (b) **All health insurance issued or delivered for issuance in Missouri in the small**
- 35 **employer market is discontinued and coverage under such health insurance is not renewed;**
- 36 [(6) The small employer carrier elects to nonrenew all of its health benefit plans
- 37 delivered or issued for delivery to small employers in this state. In such a case the carrier shall:
- 38 (a) Provide advance notice of its decision under this subdivision to the insurance
- 39 supervisory official in each state in which it is licensed; and
- 40 (b) Provide notice of the decision not to renew coverage to all affected small employers
- 41 and to the insurance supervisory official in each state in which an affected covered individual
- 42 is known to reside at least one hundred eighty days prior to the nonrenewal of any health benefit
- 43 plan by the carrier. Notice to the insurance supervisory official under this paragraph shall be
- 44 provided at least three working days prior to the notice to the affected small employers;
- 45 (7)] (8) **The director finds that the continuation of the coverage would:**
- 46 (a) **Not be in the best interests of the policyholders or certificate holders; or**
- 47 (b) **Impair the carrier's ability to meet its contractual obligations.**

48

49 In such instance the director shall assist affected small employers in finding replacement  
50 coverage.

51 2. A small employer carrier that elects not to renew a health benefit plan [under]  
52 **pursuant to** subdivision [(6)] (7) of subsection 1 of this section shall be prohibited from writing  
53 new business in the small employer market in this state for a period of five years from the date  
54 of notice to the director.

55 3. In the case of a small employer carrier doing business in one established geographic  
56 service area of the state, the provisions of this section shall apply only to the carrier's operations  
57 in such service area.

58 **4. A small employer carrier offering coverage through a network plan shall not be**  
59 **required to offer coverage or accept applications pursuant to subsection 1 or 2 of this**  
60 **section:**

61 (1) **To an eligible person who no longer resides, lives or works in the service area**  
62 **or in an area for which the carrier is authorized to do business, but only if coverage is**  
63 **terminated pursuant to this subdivision uniformly without regard to any health status-**  
64 **related factor of any covered individual; or**

65 (2) **To a small employer that no longer has an enrollee in such plan who lives,**  
66 **resides or works in the service area of the carrier or the area for which the carrier is**  
67 **authorized to do business.**

68 **5. In the case of health insurance coverage that is made available by a small**  
69 **employer carrier only through one or more bona fide associations, references to "plan**  
70 **sponsor" in this section is deemed, with respect to coverage provided to a small employer**  
71 **member of the association, to include a reference to such employer.**

379.940. 1. (1) Every small employer carrier shall, as a condition of transacting  
2 business in this state with small employers, actively offer to small employers [at least two health  
3 benefit plans. One plan offered by each small employer carrier shall be a basic health benefit  
4 plan and one plan shall be a standard health benefit plan] **all health benefit plans it actively**  
5 **markets to small employers in this state.**

6 (2) (a) A small employer carrier shall issue a [basic health benefit plan or a standard]  
7 health benefit plan to any eligible small employer that applies for [either] such plan and agrees  
8 to make the required premium payments and to satisfy the other reasonable provisions of the  
9 health benefit plan not inconsistent with sections 379.930 to 379.952.

10 (b) In the case of a small employer carrier that establishes more than one class of  
11 business pursuant to section 379.934, the small employer carrier shall maintain and issue to  
12 eligible small employers [at least one basic health benefit plan and at least one standard] **all**

13 health benefit [plan] **plans** in each class of business so established. A small employer carrier  
14 may apply reasonable criteria in determining whether to accept a small employer into a class of  
15 business, provided that:

16 a. The criteria are not intended to discourage or prevent acceptance of small employers  
17 applying for a [basic or standard] health benefit plan;

18 b. The criteria are not related to the health status or claim experience of the small  
19 employer;

20 c. The criteria are applied consistently to all small employers applying for coverage in  
21 the class of business; and

22 d. The small employer carrier provides for the acceptance of all eligible small employers  
23 into one or more classes of business. The provisions of this paragraph shall not apply to a class  
24 of business into which the small employer carrier is no longer enrolling new small employers.

25 [(3) A small employer is eligible under subdivision (2) of this subsection if it employed  
26 at least three or more eligible employees within this state on at least fifty percent of its working  
27 days during the preceding calendar quarter.

28 (4) The provisions of this subsection shall be effective one hundred eighty days after the  
29 director's approval of the basic health benefit plan and the standard health benefit plan developed  
30 pursuant to section 379.944, provided that if the small employer health reinsurance program  
31 created pursuant to sections 379.942 and 379.943 is not yet in operation on such date, the  
32 provisions of this subsection shall be effective on the date that such program begins operation.]

33 2. Health benefit plans covering small employers shall comply with the following  
34 provisions:

35 (1) A health benefit plan shall not deny, exclude or limit benefits for a covered individual  
36 for losses incurred more than twelve months following the effective date of the individual's  
37 coverage due to a preexisting condition. A health benefit plan shall not define a preexisting  
38 condition more restrictively [than:

39 (a) A condition that would have caused an ordinarily prudent person to seek medical  
40 advice, diagnosis, care or treatment during the six months immediately preceding the effective  
41 date of coverage;

42 (b)] A condition for which medical advice, diagnosis, care or treatment was  
43 recommended or received during the six months immediately preceding the effective date of  
44 coverage; [or

45 (c)] **provided, however, that** a pregnancy existing on the effective date of coverage  
46 **shall not be considered a preexisting condition.**

47 (2) A health benefit plan shall waive any time period applicable to a preexisting  
48 condition exclusion or limitation period with respect to particular services for the period of time

49 an individual was previously covered by [qualifying previous] **creditable** coverage [that  
50 provided benefits with respect to such services, provided that the qualifying previous]:

51 **(a) The creditable coverage was continuous to a date not less than [thirty] sixty-three**  
52 **days prior to the [effective] date of application for the new coverage. [This subdivision does**  
53 **not preclude application of any waiting period applicable to all new enrollees under the health**  
54 **benefit plan]; and**

55 **(b) The aggregate period of such individual's creditable coverage is not less than**  
56 **twelve months.**

57 (3) A health benefit plan may exclude coverage for late enrollees for the greater of  
58 eighteen months or provide for an eighteen-month preexisting condition exclusion, provided that  
59 if both a period of exclusion from coverage and a preexisting condition exclusion are applicable  
60 to a late enrollee, the combined period shall not exceed eighteen months from the date the  
61 individual enrolls for coverage under the health benefit plan[.];

62 **(4) A small employer carrier is prohibited from imposing any preexisting condition**  
63 **exclusion in the following cases:**

64 **(a) A small employer carrier shall not impose any preexisting condition exclusion**  
65 **relating to pregnancy as a preexisting condition;**

66 **(b) Subject to paragraph (e) of this subdivision, a small employer carrier shall not**  
67 **impose any preexisting condition exclusion in the case of an individual who, as of the last**  
68 **day of the thirty-day period beginning with the date of birth, is covered under creditable**  
69 **coverage;**

70 **(c) Subject to paragraph (e) of this subdivision, a small employer carrier shall not**  
71 **impose any preexisting condition exclusion in the case of a child who is adopted or placed**  
72 **for adoption before attaining eighteen years of age and who, as of the last day of the thirty-**  
73 **day period beginning on the date of adoption or placement for adoption, is covered under**  
74 **creditable coverage. The previous sentence shall not apply to coverage before the date of**  
75 **adoption or placement for adoption;**

76 **(d) A small employer carrier shall not impose any preexisting condition exclusion**  
77 **in the case of a condition for which medical advice, diagnosis, care or treatment was**  
78 **recommended or received for the first time while the covered person held creditable**  
79 **coverage, and the medical advice, diagnosis, care or treatment was a covered benefit under**  
80 **the plan, provided that the creditable coverage was continuous to a date not more than**  
81 **sixty-three days prior to the enrollment date of the new coverage;**

82 **(e) Paragraphs (b) and (c) of this subdivision shall no longer apply to an individual**  
83 **after the end of the first sixty-three-day period during all of which the individual was not**  
84 **covered under any creditable coverage;**

85           [(4)] (5) (a) Except as provided in paragraph (d) of this subdivision, requirements used  
86 by a small employer carrier in determining whether to provide coverage to a small employer,  
87 including requirements for minimum participation of eligible employees and minimum employer  
88 contributions, shall be applied uniformly among all small employers with the same number of  
89 eligible employees applying for coverage or receiving coverage from the small employer carrier.

90           (b) A small employer carrier may vary application of minimum participation  
91 requirements only by the size of the small employer group.

92           (c) a. Except as provided in paragraph (b) of this subdivision, in applying minimum  
93 participation requirements with respect to a small employer, a small employer carrier shall not  
94 consider employees or dependents who have [qualifying existing] **creditable** coverage in  
95 determining whether the applicable percentage of participation is met.

96           b. With respect to a small employer with ten or fewer eligible employees, a small  
97 employer carrier may consider employees or dependents who have coverage under another health  
98 benefit plan sponsored by such small employer in applying minimum participation requirements.

99           (d) A small employer carrier shall not increase any requirement for minimum employee  
100 participation or any requirement for minimum employer contribution applicable to a small  
101 employer at any time after the small employer has been accepted for coverage.

102           [(5)] (6) (a) If a small employer carrier offers coverage to a small employer, the small  
103 employer carrier shall offer coverage to all of the eligible employees of a small employer and  
104 their dependents. A small employer carrier shall not offer coverage to only certain individuals  
105 in a small employer group or to only part of the group, except in the case of late enrollees as  
106 provided in subdivision (3) of this subsection.

107           (b) **In accordance with the federal Health Insurance Portability and Accountability**  
108 **Act of 1996**, a small employer carrier shall not modify a [basic or standard] health benefit plan  
109 with respect to a small employer or any eligible employee or dependent through riders,  
110 endorsements or otherwise, to restrict or exclude coverage for certain diseases or medical  
111 conditions otherwise covered by the health benefit plan.

112           3. (1) A small employer carrier shall not be required to offer coverage or accept  
113 applications pursuant to subsection 1 of this section in the case of the following:

114           (a) To a small employer, where the small employer is not physically located in the  
115 carrier's established geographic service area;

116           (b) To an employee, when the employee does not work or reside within the carrier's  
117 established geographic service area; or

118           (c) Within an area where the small employer carrier reasonably anticipates, and  
119 demonstrates to the satisfaction of the director, that it will not have the capacity within its  
120 established geographic service area to deliver service adequately to the members of such groups

121 because of its obligations to existing group policyholders and enrollees.

122 (2) A small employer carrier that cannot offer coverage pursuant to paragraph (c) of  
123 subdivision (1) of this subsection may not offer coverage in the applicable area to new cases of  
124 employer groups [with more than twenty-five eligible employees] or to any small employer  
125 groups until the later of one hundred eighty days following each such refusal or the date on  
126 which the carrier notifies the director that it has regained capacity to deliver services to small  
127 employer groups.

128 4. A small employer carrier shall not be required to provide coverage to small employers  
129 pursuant to subsection 1 of this section for any period of time for which the director determines  
130 that requiring the acceptance of small employers in accordance with the provisions of subsection  
131 1 of this section would place the small employer carrier in a financially impaired condition.

132 [5. Sections 379.930 to 379.938 and sections 379.942 to 379.950 shall become effective  
133 July 1, 1993, this section and section 379.952 shall become effective July 1, 1994.]

379.952. 1. Each small employer carrier shall actively market health benefit plan  
2 coverage, including the basic and standard health benefit plans, to eligible small employers in  
3 the state. [If a small employer carrier denies coverage to a small employer on the basis of the  
4 health status or claims experience of the small employer or its employees or dependents, the  
5 small employer carrier shall offer the small employer the opportunity to purchase a basic health  
6 benefit plan or a standard health benefit plan.]

7 2. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier  
8 or agent or broker shall, directly or indirectly, engage in the following activities:

9 (a) Encouraging or directing small employers to refrain from filing an application for  
10 coverage with the small employer carrier because of the health status, claims experience,  
11 industry, occupation or geographic location of the small employer;

12 (b) Encouraging or directing small employers to seek coverage from another carrier  
13 because of the health status, claims experience, industry, occupation or geographic location of  
14 the small employer.

15 (2) The provisions of subdivision (1) of this subsection shall not apply with respect to  
16 information provided by a small employer carrier or agent or broker to a small employer  
17 regarding the established geographic service area or a restricted network provision of a small  
18 employer carrier.

19 3. (1) Except as provided in subdivision (2) of this subsection, no small employer carrier  
20 shall, directly or indirectly, enter into any contract, agreement or arrangement with an agent or  
21 broker that provides for or results in the compensation paid to an agent or broker for the sale of  
22 a health benefit plan to be varied because of the health status, claims experience, industry,  
23 occupation or geographic location of the small employer.

24           (2) Subdivision (1) of this subsection shall not apply with respect to a compensation  
25 arrangement that provides compensation to an agent or broker on the basis of percentage of  
26 premium, provided that the percentage shall not vary because of the health status, claims  
27 experience, industry, occupation or geographic area of the small employer.

28           4. A small employer carrier shall provide reasonable compensation, as provided under  
29 the plan of operation of the program, to an agent or broker, if any, for the sale of a basic or  
30 standard health benefit plan.

31           5. No small employer carrier shall terminate, fail to renew or limit its contract or  
32 agreement of representation with an agent or broker for any reason related to the health status,  
33 claims experience, occupation, or geographic location of the small employers placed by the agent  
34 or broker with the small employer carrier.

35           6. No small employer carrier or producer shall induce or otherwise encourage a small  
36 employer to separate or otherwise exclude an employee from health coverage or benefits  
37 provided in connection with the employee's employment.

38           7. Denial by a small employer carrier of an application for coverage from a small  
39 employer shall be in writing and shall state the reason or reasons for the denial with specificity.

40           8. The director may promulgate rules setting forth additional standards to provide for the  
41 fair marketing and broad availability of health benefit plans to small employers in this state.

42           9. (1) A violation of this section by a small employer carrier or a producer shall be an  
43 unfair trade practice [under] **pursuant to** sections 375.930 to 375.949, RSMo.

44           (2) If a small employer carrier enters into a contract, agreement or other arrangement  
45 with a third-party administrator to provide administrative marketing or other services related to  
46 the offering of health benefit plans to small employers in this state, the third-party administrator  
47 shall be subject to this section as if it were a small employer carrier.

48           **10. For purposes of health benefit plans sold to employers of exactly two eligible**  
49 **employees and health benefit plans sold to employers with more than twenty-five eligible**  
50 **employees but not more than fifty eligible employees, sections 379.934 and 379.936 shall**  
51 **become effective July 1, 2002.**